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ABSTRACT

Since suicide may provoke emotions of fear, anxiety, disbelief, and anger, attitudes of avoidance and indifference may occur. This booklet on the issue of suicide was written to provide a university community with a framework of information and some methods of intervention, and to develop some expectations. Sixteen myths about suicide which deter individuals from becoming involved are listed along with the facts that contradict the myths. Although there is no single pattern or causative factor in suicide, indicators such as a feeling of hopelessness and a belief that things are "out of control" are among the most frequent. Intervention processes are discussed, as well as how to assess the circumstances (method, intentions, mitigating circumstances). The direct, caring question "Are you thinking of commiting suicide?" is recommended. Five points to remember in intervention are listed. Referral agencies at the University of Minnesota are listed. Recommendations on dealing with the aftermath of a suicide are provided. A bibliography is included. (ABL)

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The Issue is Suicide

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Dedication

This booklet is dedicated to the memory of Andrew Strom, a University student who committed suicide. It is hoped that this information will aid in the intervention and prevention of suicide. And, that suicide will be discussed openly with individuals who are contemplating suicide and the survivors of those who have committed suicide.

The Suicide Prevention Fund, established in Andrew's memory, made possible the publication of this booklet.

Introduction

Suicide is not a neutral word, it is not a neutral behavior. As a word it evokes apprehension and creates a desire to avoid or detach oneself from a discussion. As a behavior it evokes powerful emotional reactions regardless of the outcome. Fear, anxiety, disbelief and anger are but a few of the emotions that create an atmosphere which impedes a discussion or involvement in the issues of suicide. As a consequence, attitudes and actions of avoidance and indifference occur. However, with adequate information and the creation of realistic expectancies, this avoidance and indifference may be alleviated and replaced with positive actions and reactions. That is the purpose of this booklet. It is not a psychological treatise nor an all-inclusive reference. Rather, it is written to provide a framework of information, some methods of intervention and to develop some expectations. It is written in the hope that members of the University community—faculty, staff, students—will engage in the creation of a caring and confrontive community which will present the suicidal person with some alternatives to his/her dilemma.

Suicide is a traumatic event for the individual and for all of those people who have some connection with him/her. Shneidman (1972) has stated:

> *Human understanding is the most effective weapon against suicide. The greatest need is to deepen the awareness and sensitivity of people to their fellow men. (pp 108-109)*

Let this be the beginning of greater awareness and sensitivity by all of the University community.

The Issue is Suicide

Suicide is a highly personalized and individualized behavior in reaction to a perceived set of life stresses and situations. Statistics and demographics can show the probability of suicide and that may be important to know. However, regardless of the data, the question for an individual who becomes aware that another person is possibly contemplating suicide is "Is this person here with me right now wanting to commit suicide and what can I do about it?"

An encounter with a suicidal person is always a deeply emotional experience. There is a fear of not knowing what to do, or doing the wrong thing. But, the basic empathic "I care about you" indicates that there is hope and help, two key ingredients in the intervention process. Misinformation often prevents individuals from becoming involved for fear of making a situation worse. There are many myths about suicide which deter individuals from becoming involved. What are the myths and what are the facts?

Myth: *People who talk about suicide rarely attempt or commit suicide.*

Fact: *Approximately 70-75% of the people who attempt or commit suicide have given some verbal or non-verbal clue to their intentions.*

Myth: *The tendency toward suicide is inherited.*

Fact: *Suicide has no characteristic genetic quality. Suicidal patterns in a family are a result of other factors and may result from a belief in the myth which facilitates suicidal actions.*

Myth: *The suicidal person wants to die.*

Fact: *Suicidal persons often reveal considerable ambivalence about living vs. dying and frequently call for help before and after a suicide attempt.*

Myth: *All suicidal persons are depressed.*

Fact: *Depression is often associated with suicidal feelings but not all persons who attempt or commit suicide are depressed. A number of other emotional factors may be involved.*

Myth: *Suicidal persons are mentally ill.*

Fact: *Many persons who have attempted or commited suicide would not have been diagnosed as mentally ill.*

Myth: *Once a person has attempted suicide, s/he will always be suicidal.*

Fact: *After a suicide attempt, a person may be able to manage his/her life appropriately and engage in no further suicidal action.*

Myth: *Asking, "Are you thinking about committing suicide will lead the person to a suicide attempt."*

Fact: *Asking a direct, caring question will often minimize the anxiety and act as a deterrent to suicidal behavior.*

Myth: *Suicide is more common in lower socio-economic groups.*

Fact: *Suicide crosses all socio-economic group boundaries.*

Myth: *Suicidal persons rarely seek medical help.*

Fact: *Studies of persons who have committed suicide indicate that 50% have sought medical help within six months of their action.*

Myth: *Suicide happens without warning.*

Fact: *Persons who have attempted or committed suicide usually give some indication of their intended behavior.*

Myth: *"Good circumstances" prevent suicide.*

Fact: *Frequently the opposite is true. Physicians, dentists and psychiatrists have high suicide rates.*

Myth: *Suicide and attempted suicide are the same class of behavior.*

Fact: *Attempted suicide is a behavior with its own characteristics, not just a failed suicide. It signals a disturbed situation.*

Myth: *Motives or causes of suicide are readily established.*

Fact: *Suicide is usually a lengthy and complex pattern of behavior where precise motives are difficult to ascertain.*

Myth: *Suicide is related to weather phenomenon.*

Fact: *From studies it appears that neither suicide nor attempted suicide is significantly related to weather phenomenon.*

Myth: *Improvement in a suicidal person means the danger if over.*

Fact: *There is a significant danger within the first 90 days after a suicidal person is released from hospitalization.*

Myth: *Only a mental health professional can prevent suicide.*

Fact: *Suicide prevention by lay persons and centers has been an important, significant part of suicide prevention activities.*

These myths and facts were synthesized from works by Blimling and Miltenberger (1981), Resnik (1968), Resnik and Hawthorne (1973) and Shneidman and Farberow (1961).

Some Indicators

Approximately 70-75% of the individuals who attempt or commit suicide *DO* give some indication of their impending action. What are some of the indicators? Gollman (1971) lists some indicators of susceptibility toward self-destruction: previous attempts; suicidal threats; chronic illness; feeling isolated; grief; financial stress; severe depression; domestic difficulties; alcoholism; chronic use of other chemicals; a family history of suicide; and living alone.

There is no single pattern or causative factor in suicide. However, most often there is an indication of a feeling of hopelessness and a belief that things are "out of control." These two feelings, in particular, are *strong* indicators of potential suicide.

All indications must be taken seriously. The individual's actions may be a "cry for help." But, if help does not arrive as anticipated, a suicide may result. It is not known how many suicides were cries for help that did not get communicated properly. It is known that the cry for help is prevalent among attempted suicides and needs a response.

Intervention

How to respond! Intervention is a scary process. The feeling of a rapidly pounding heart, sweaty palms and other indicators of anxiety will most likely be felt by anyone undertaking an intervention. How to begin! The best intervention is to ask directly and caringly:

Are you thinking about committing suicide?

Asking will not put the idea into his/her head. Rather, if the person is thinking about committing suicide, s/he will finally have found someone who cares and is willing to talk about this "taboo" subject. The person is often relieved and able to begin an exploration of alternatives and to engage in some catharsis. If s/he is not suicidal, s/he may be greatly relieved to discover that things have not become "that bad."

Some assessment of the circumstances needs to be made. How lethal is the proposed method of suicide? What are the person's exact intentions? What mitigating circumstances might be present?

The lethality of the plan can range from a well thought out action involving a very lethal method (hanging, shooting, poisoning, jumping—with the method very available) to a very low level of lethality (a nebulous idea with little feasibility of succeeding). The more specific the plan and the more lethal the method, the higher the risk.

The persons's intentions can range from fleeting, vague thoughts about "maybe thinking about it" to a highly specific intention of dying. There is often a significant ambivalence about dying. The person may move back and forth from a high indication of a desire to die to a high indication of a desire to live. The greater the desire the die, the higher the risk.

Mitigating circumstances are those factors which can negatively or positively affect the suicide process. Negative factors are those such as intoxication, alcoholism, disorientation, misperceptions of reality, confusion, high levels of stress and disorganization and feelings of hopelessness or being out of control. Positive factors are those such as a supporting group of friends or relatives, good physical fitness, no previous

suicide attempts or other indicators. The strongest factor is a support group for the individual.

It is important to determine if the person has the method immediately available. If so, s/he should be asked for the pills, gun, knife, etc. and these should be removed for safekeeping.

MOST IMPORTANTLY, remember that the direct, caring question should be a neutral one like "Are you thinking of committing suicide?" Questions like "You're NOT thinking of committing suicide are you?" indicate that the answer you want to hear is "No, I'm not." and do nothing to facilitate a resolution of the individual's suicidal crisis.

The following are some points to remember:

1) NEVER promise total confidentiality. Explain to the person that you may need to discuss the situation with another individual in order to provide the best possible service to him/her.

2) BE ABSOLUTELY willing to discuss the suicidal thoughts and feelings of the individual in as much detail as possible to determine the immediacy of the danger, to determine the best referral source and to provide the person with an outlet for his/her thoughts and emotions.

3) Verbally and non-verbally indicate YOUR genuine concern.

4) Involve the person in a SUICIDE CONTRACT. This means asking the person to promise that s/he will contact you prior to attempting suicide in the future so that the two of you can discuss available alternatives. It sounds strange, but it works.

5) REFER the person to an appropriate agency for assistance. AND, be willing to accompany the person to the initial contact session.

Intervention is one aspect. You may come upon someone who has attempted or completed suicide. If appropriate, render assistance by aiding in stopping bleeding, untying a rope, etc. In all instances, contact authorities for assistance.

On campus—**133** for police emergency.

Off campus—**911** for police emergency.

Be certain to give the dispatcher complete information as to the location of the incident, your perceptions of what has happened and await their arrival.

Referral Agencies

At the University of Minnesota:

Mental Health Clinic, Boynton Health Service, 373-4022

Student Counseling Bureau, 101 Eddy Hall, 373-4193

Emergency Receiving, University Hospitals, 373-8543

In the community:

YES—crisis counseling over the phone, 24 hours a day, seven days a week. 339-7033

NEON—face-to-face outreach counseling service from 8 p.m. to 8 a.m., 7 nights a week. 339-0895

Crisis Intervention Center (CIC)—24 hour walk-in at Hennepin County Medical Center, 701 Park Avenue, Minneapolis. 347-3161

Suicide Prevention Hotline—suicide counseling over the phone, 24 hours a day, 7 days a week. 347-2222

There are other agencies available at varying times. These are the most available agencies. YES can provide further information on other community agencies. All of the above have no charges except ER.

The Aftermath

An attempted or completed suicide is always a traumatic experience in a college setting. The survivors have to deal with the initial shock element as well as the lack of any established patterns of behavior upon which they can rely. Different reactions are experienced by peers, colleagues, staff, friends, faculty, parent and significant others. Particularly in a residence hall, staff need to be aware of these reactions in order

to respond appropriately.

Any or all of the following may be present:
—feeling of abandonment.
—disbelief.
—confusion.
—anger—both at the person and at self.
—resentment.
—anxiety.
—bewilderment.
—fear.
—respect.
—idealization of the person.
—failure—"What didn't I do?"
—blame—"I should have been able to . . ."
—guilt—"It's my fault for not . . ."
—humiliation.

These are some of the most common reactions. Grief is a common reaction and individuals may experience periods of denial, rage and anger, bargaining, depression and acceptance.

> The person who commits suicide puts his psychological skeleton in the survivor's closet.
> (Shneidman, 1969, p. 22)

Whether there is a completed suicide or an attempt, Shneidman's statement rather succinctly defines what happens. And, individuals do not want to be placed in the position of having to cope with someone's "psychological skeleton." Consequently, the tendency to avoid or to appear indifferent toward suicide occurs. Hopefully with information and the development of a caring, responding attitude, the University community can respond to individuals who are suicidal in a positive and confrontive manner. And, this same caring can also be shown to the survivors indicating that there are those who care.

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